Exhibit 24

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LAUNCHING THE MOON SHOT FOR CANCER

December 1, 2015:

Meeting with Vice President Biden

National Immunotherapy Coalition

CancerMoonShot2020.org

V5

Cancer MoonShot 2020:
A NATIONAL IMMUNOTHERAPY COALITION FOR CANCER

The Cancer QUILT Program to Develop a Cancer Immunotherapy for N=1 by 2020

Patrick Soon-Shiong, M.D., FRCS(C), FACS

Background: There are unique times when events and advances in technologies converge to elicit a quantum leap in progress. That time is now for the rapid exploitation of imunotherapy for the benefit of millions of cancer patients. Our knowledge in the worlds of genomics, proteomics, immunology and immunotherapy has advanced and converged at an unprecedented speed. The cloning of the human genome has led to an enormous knowledge base about how cancers are initiated and progress. There now is clear proof of concept that immunotherapy can cure some forms of cancer, but much work is still needed.

There are two major challenges at hand: one involves immunotherapy itself, and the other involves our current standard of care, which includes high-dose chemotherapy. Immunotherapy differs in several ways from conventional therapeutics, such as chemotherapy, small molecule targeted therapies and radiation. Conventional therapeutics are no longer in the body when the therapy is terminated. For the most part, they work independently of each other, and combinations often exacerbate toxicity.

On the other hand, the effects of immunotherapeutics such as vaccines are often long-lasting, continuing well after therapy is stopped. More importantly, it has been shown that different immunotherapies can enhance one another and can often act synergistically.

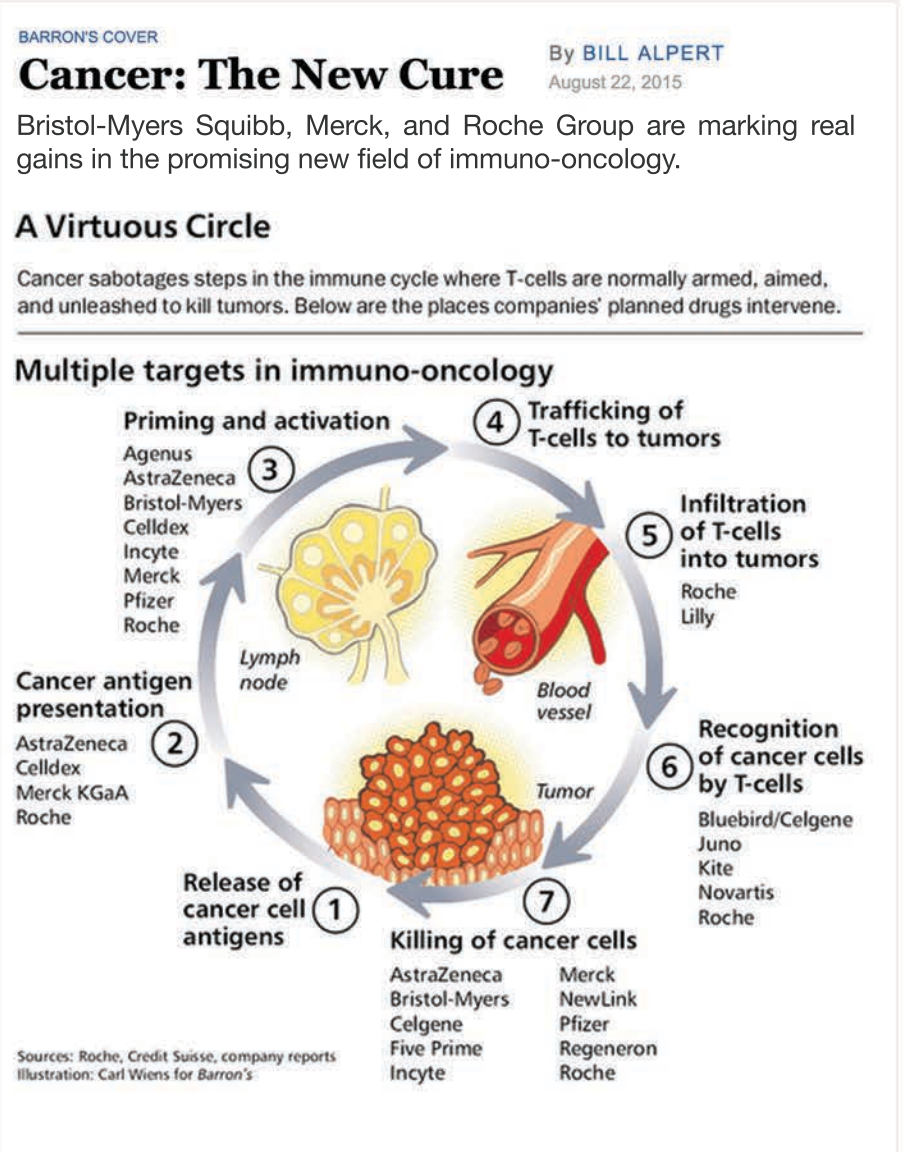
"The effects of immunotherapeutics such as vaccines...are often long-lasting, continuing well after therapy is stopped. More importantly, it has been shown that different immunotherapies can actually enhance each other and often act synergistically. "

Combinations of immunotherapies can be carried out because for the most part, they induce limited toxicity.

There are dozens of new immunotherapeutic agents being evaluated clinically as well as dozens more being evaluated preclinically.

However, each of these immunotherapeutic agents is being developed in an independent silo by independent companies. It often takes years to find out if any single agent has real clinical benefit. Only then can that agent be used in combination with other agents. Moreover, more often than not an individual agent is discarded due to its apparent lack of clinical benefit despite its potential benefit to patients when used in combination therapy.

Members joining the NIC recognize this development challenge, and are committed to creating a more unified, coordinated immunotherapeutic development effort.

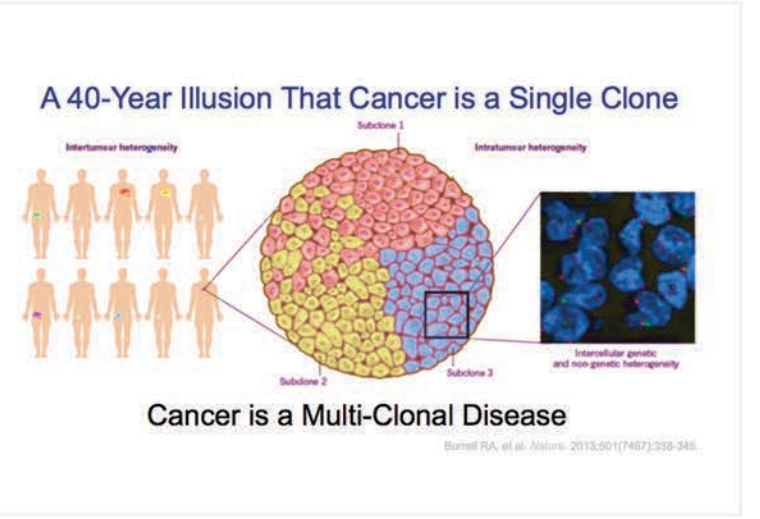


Maximum Tolerated Dose of Chemotherapy: The Illusion of Clonal Dominance

Current standards of care presents another paradox. The wave of excitement regarding harnessing our immune system to fight cancer is growing, but at the same time, current standards of care involve high-dose chemotherapy and radiotherapy regimens that wipe out the patient's immune defenses. This standard practice of high-dose chemotherapy has been propagated for over 40 years on the illusion that cancer resulted from a single mutated clone, growing in a linear fashion. On this basis, single agent targeted therapy has been the focus of drug development for decades as the answer to toxic chemotherapy.

The scientific community has now realized that this long held assumption that cancer cells grow in a linear fashion from a single clonally dominant mutant cell is incorrect. This insight may have significant outcome implications both for the practice of high dose intermittent chemotherapy, as well as for the administration of single agent targeted therapy. Over the last several years, scientists studying the cancer process have elucidated the surprising fact that the vast majority of cancers arise and progress due to numerous mutations in cancer cells, and that in fact cancer is a multi-clonal disease. Moreover, each patient's cancer is often unique in terms of the nature and number of mutations. This is pinpointed as one of the major reasons why many existing therapeutic regimens designed to target a single or even a few mutations have had limited success to date. Thus administering high-dose chemotherapy, which impedes the immune system and may stimulate resistant mutant clones, appears to be doomed to failure. This insight requires a paradigm shift in the delivery of chemotherapy. The scientific community has demonstrated the immunomodulatory effects of metronomic low-dose chemotherapy. This immunomodulatory effect combined with low dose metronomic chemotherapy must be explored as a new paradigm in cancer care.

"THE PARADOX OF MAXIMUM TOLERATED DOSE OF CHEMOTHERAPY: THE ILLUSION OF CLONAL DOMINANCE"



With the advent of next generation whole genome sequencing and RNA analysis of protein pathways, new insights into the dynamic evolution of cancer has been gained. In patients with Triple Negative Breast Cancer (TNBC), clinicians at the University of Washington demonstrated intrapatient and temporal heterogeneity that may lead to a lack of response to identified targeted therapies.

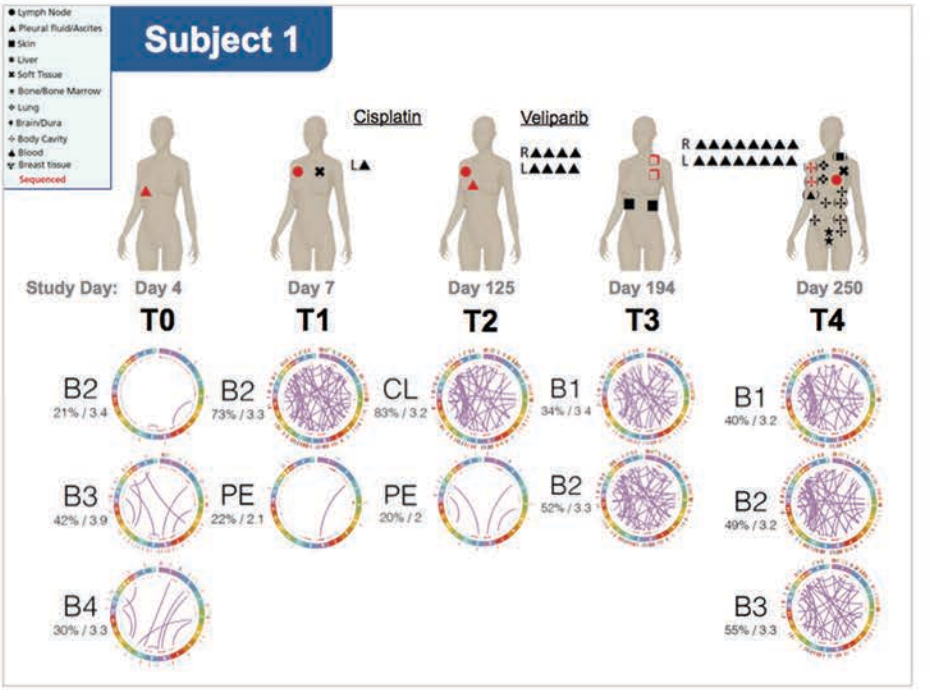
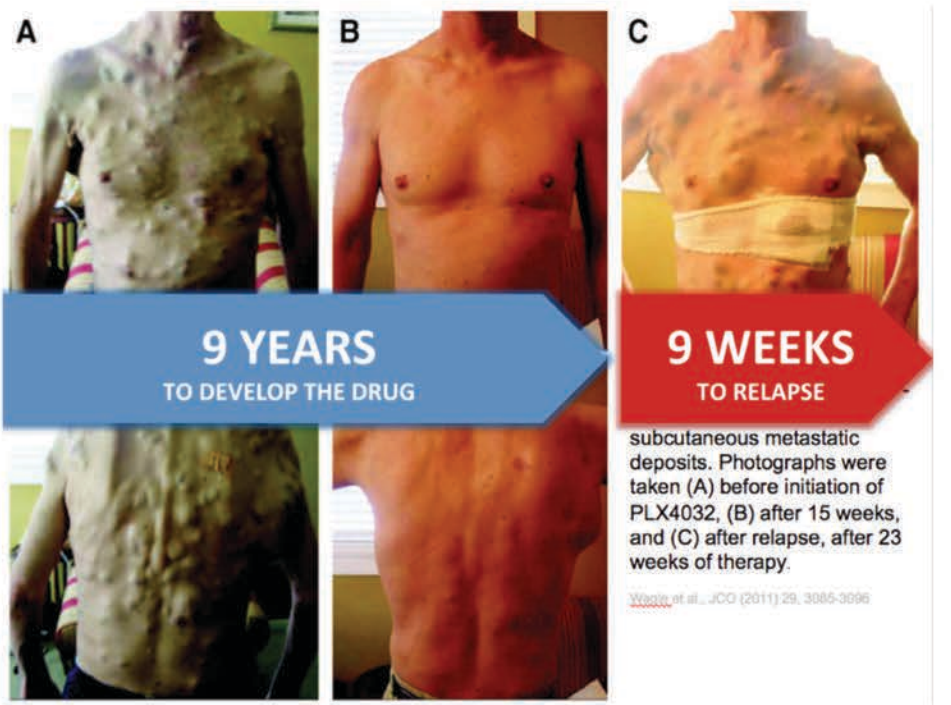


Figure 1: San Antonio Breast Cancer Symposium December 2015: Integrating whole exome sequencing data with RNAseq and quantitative proteomics to better inform clinical treatment decisions in patients with metastatic triple negative breast cancer. Soon-Shiong P, Rabizadeh S, Benz S, Cecchi F, Hembrough T, Mahen E, Burton K, Song C, Senecal F, Schmechel S, Pritchard C, Dorschner M, Blau S, Blau A. NantOmics, Culver City, CA; NantOmics, Santa Cruz, CA; NantOmics, Rockville, MD; University of Washington, Seattle, WA.

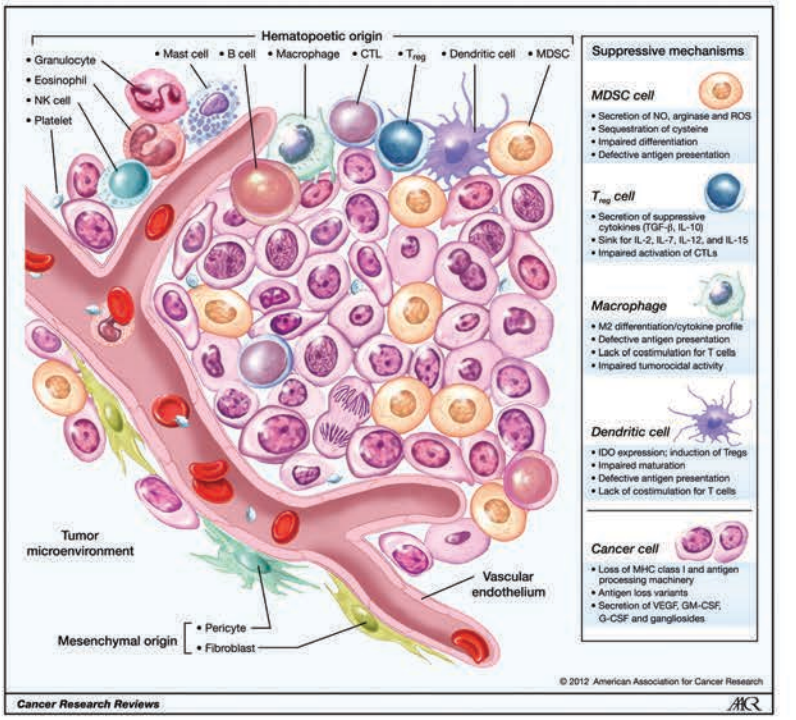
Gerlinger stated in Nature Genetics 2014 "…an illusion of clonal dominance when assessed by single biopsies. The presence of sub clonal driver events in solid tumours may provide an explanation for the inevitable acquisition of resistance to targeted therapeutics in advanced disease." This is vividly demonstrated below in a patient with metastatic melanoma, leaving us with a disconcerting possibility that "resistance is therefore a fait accompli – the time to recurrence is simply the interval required for the subclone to repopulate the lesion." - Diaz et al. Nature 486, 537-540 (2012)



The Age of Cancer Immunotherapy Has Dawned:

The human immune system has evolved over the millennia to combat an enormous range of invasive entities, such as viruses and bacteria. Indeed, the immense diversity of the healthy, intact immune system is believed to be responsible for eliminating the many potentially cancerous cells that arise during a lifetime. This is evidenced by studies that have shown that imunocompromised individuals, such as long-term AIDS patients, develop more cancers than healthy individuals. This unique diversity and the remarkable ability to survey and eliminate harmful entities define the human immune system, which can be exploited to combat the individual mutations reflected in so-called neo-antigens in tumor cells. The potential now exists to develop immunotherapies tailored to the unique tumor signature of individual patients.

Enhanced understanding of how individual components of the immune system function, combined with new findings in cancer cell biology, can now drive the development of new immunotherapies for cancer. In the last few years several of these immunotherapies have been approved by the FDA for patients with certain forms of lung cancer, melanoma, and prostate cancer. However, these approvals benefit only a fraction of cancer patients, and much more progress is still to be made.



Cancer care is undergoing a paradigm shift from highly toxic, high dose chemotherapy to considerably less toxic immunotherapy. Significantly, combinations of low dose chemotherapy, radiotherapy and immunotherapeutics can be used with fewer compounding toxicities, thus providing a better quality of life for the patient. A major point of emphasis is that each type of cancer immunotherapy appears to activate a different component of the immune system. When used in combination, they are much more effective. To date, there are dozens of novel cancer immunotherapeutic agents in active clinical studies.

Addressing the Obstacles and the Paradoxes:

As described above, this field faces major challenges to rapid progress. Numerous pharmaceutical and biotech companies each have their own preclinical- and clinical-stage immunotherapeutic agents in the form of antibodies, immune cells, and vaccines. Taken together with the enormous heterogeneity and antigenic profiles found in individual patients' cancer cells, it is a tremendous challenge to define which of these numerous agents, and in which combinations, will prove optimal for each type and stage of cancer.

Additionally, combating the persistent practice and dogma of high-dose chemotherapy and radiotherapy requires widespread validation of a new paradigm of cancer care: one that prevents the immune system from being inadvertently obliterated by the very treatment being administered.

> "...combinations of low dose chemotherapy, radiotherapy and immunotherapeutics can be used with fewer compounding toxicities and thus provide a better quality of life for the cancer patient."

The National Immunotherapy Coalition:

For this reason we are proposing a **National Immunotherapy Coalition (NIC)** to collectively undertake a **QUILT** (**QU**antitative, **I**ntegrative, **Li**felong **T**rial) program in patients with cancer to develop a vaccine based, combinatorial immunotherapy approach to cancer care.

This will not be a simple, one-dimensional enterprise. Through integrative and collaborative efforts in informatics, a patient tumor's genetic makeup and unique properties can be evaluated rapidly. This makes feasible the development of patient-specific vaccines directed against individual neoepitopes, which reflect mutations in a patient's tumor. These vaccines in turn can activate a cascade of immune attacks against the tumor. Vaccines targeting drug-resistant and aggressive cancer cells more likely to metastasize have been identified, and are being thoroughly evaluated. Multiple combination immunotherapies assembled include conventional vaccines, patient-specific vaccines, monoclonal antibodies, immune-enhancing agents, and immune cell-based therapy. This enterprise also involves low-dose chemotherapy and targeted therapies that enhance the effects of immunotherapy. Ultimately, it will target multiple cancer types.

This QUILT Program will be implemented by National Immunotherapy Coalition, where the Food and Drug Administration, National Cancer Institute, big pharma, biotech companies, payers, and private foundations can pool resources to more rapidly define which new agents and combinations of immunotherapies will most benefit patients. Regulatory agencies such as the FDA can provide guidance for combinations of innovative agents amongst these various entities. Insurance companies and self insured payers can gain insight into outcomes and cost to reimburse for value.

> "This makes feasible the development of patient-specific vaccines directed against individual neoepitopes, which reflect mutations in a patient's tumor. These vaccines in turn can activate a cascade of immune attack against that tumor."

Members of the National Immunotherapy Coalition have gathered to discuss obstacles that may impede the Cancer MoonShot, and the goal of establishing an effective vaccine-based, combinatorial immunotherapy treatment for this disease in 4 years rather than decades.

The Mission:

A union of forces is needed to successfully achieve the goal of combinatorial immunotherapies in the war against cancer. The goal is to obtain a commitment from members of the National Immunotherapy Coalition, collectively addressing the following obstacles that may impede rapid clinical implementation of the QUILT Program:

1. **Validation of Big Science:** Complex science involving the human immune system and the validation of the safety and efficacy of combination therapy must be tested by reputable scientific enterprises in an unbiased manner without any prejudices other than the interest of the patient.

2. **Access to novel agents and approved drugs:** One of the major challenges facing rapid progress in this field is that numerous pharmaceutical and biotech companies each have their own immunotherapeutic agents in the form of antibodies, immune cells, and vaccines in preclinical and clinical studies.

3. **FDA Regulation:** Novel approaches for the adaptive combination of novel agents in this new paradigm where the combined multi-agents serve as a systems biological approach to the treatment of cancer.

4. **Care coordination and real-time monitoring** of safety and outcomes with integration of complex molecular data, phenotypic data obtained from disparate electronic records.

5. **Ability to measure outcomes and cost** in real time to enable payors to pay for value rather than procedures and establish an adaptive learning system for enhanced predictive modeling.

6. **Network Infrastructure:** Highly secure bandwidth to transmit big data & interrogate complex molecular information on a large scale.

The QUILT Program will address each of these problems by bringing together stakeholders, each of whom have the ability to solve these interdependent obstacles within their own sphere of activity and authority.

1. **Validation of Big Science:** The NCI and major academic cancer centers should collectively address the unbiased clinical validation of the science.

2. **Access to Novel Agents and Approved Drugs:** Biotech and big pharma should commit to make available their approved drugs and drug pipeline to be tested in combination trials by credible unbiased organizations such as the NCI.

3. **FDA Regulation:** The FDA should commit to adopting innovative and adaptive clinical trials allowing combination of innovative agents to test the biological system in the era of precision medicine

4. **Care Coordination:** Academic centers and community oncologist should collaborate to enable treatment to be administrated at the local communities rather than require patients to travel to tertiary academic centers to access clinical trials. Major academic centers should commit to support the scientific education and participation of community oncologist in clinical trials, clinical practices in this new era of 21st century immunotherapy.

5. **Ability to measure outcomes and cost:** EMR vendors should commit to enable the free flow of clinical information to enable real-time measurement of outcomes and cost. Payors should establish innovative payment models to pay for value and outcomes rather than procedures.

EXECUTING THE PLAN

National Immunotherapy Coalition

December 1, 2015

The Moon Shot:
A National Immunotherapy Coalition for Cancer

The MoonShot to Develop Immunotherapies for Cancer by 2020

Goal: To validate the potential of combination immunotherapy as the next generation standard of care in cancer patients by completing randomized Phase II trials in patients at all stages of disease in up to 20 tumor types in 20,000 patients, within the next 24 months. These findings will inform Phase III trials and the MoonShot to develop a vaccine-based immunotherapy for cancer by 2020.

The QUILT Program: A Quantitative Integrative Lifelong Trial in patients with cancer undergoing next generation panomic analysis (genome, proteome, immunome and metabolome) to inform precise cancer care based on individualized and dynamic biology of the disease. The protocols will be designed to harness all the elements of the immune system (dendritic cells, T-cells, and NK cells) to combine vaccines and cell-based immunotherapy with metronomic chemotherapy and immunomodulators with the goal of durable, long-lasting remission of the disease with the highest quality of life.

The National Immunotherapy Coalition: A public-private partnership where a union of forces consisting of the government (NCI, FDA, White House, Congress), pharma and biotech industry, health care providers both academic and community caregivers, insurance industry and self-insured employers, all collectively commit to support this National Immunotherapy Initiative for Cancer.

The Steps Towards the MoonShot:

1. Establish a national and global advisory group of clinical and scientific immunotherapy experts under the guidance of the NCI and FDA to design clinical protocols of up to 20 Phase II randomized clinical trials with vaccine immunotherapy as a base and combining therapies as adjuvants to the vaccine base (checkpoint inhibitors, monoclonal antibodies, low dose chemotherapy, immuno-modulators, and low-dose radiation). Current standard of care will be used as controls across a range of tumor types spanning all stages of disease from newly diagnosed to end stage cancer.

   Timeframe: Establish advisory group - November 2015 to January 2016

2. Publicly announce the National Immunotherapy Coalition and the QUILT Program. Launch website.
Timeframe: Public announcement and website release in January 2016

3. Establish a common web based secure portal to enable providers and the oncology community at a national level to access information regarding the design and availability of trials with access to immunotherapy agents involving such trials.
Timeframe: Establish secure portal - November 2015 to February 2016

4. Amend currently approved vaccine based and immunotherapy IND protocols in scientific collaboration with the FDA and file newly drafted IND requests for QUILT Program with NCI as the IND holder.
Timeframe: Amend and file new IND protocols - November 2015 to March 2016

5. Establish a validated high throughput panomic and pan-immunomic diagnostic infrastructure as a central validated resource to perform molecular prescreening of 100,000 cancer patients with active disease
Timeframe: Identify validated diagnostic infrastructure - January 2016 to March 2016

6. Establish a secure web-based portal to integrate the panomic analysis with the clinical medical records of the 100,000 cancer patients through a web-based portal.
Timeframe: Identify the web-based integrated portal - March 2016

7. Establish a National Molecular Immunotherapy Tumor Board to identify patients eligible for each of the tumor type trials in the QUILT Program.
Timeframe: Establish a national advisory board - March 2016

8. Evaluate 100,000 patients with newly diagnosed or late stage cancer to enter into the QUILT trials in up to 20 cancer types. The goal is to enroll 20,000 patients with active and/or newly diagnosed cancer between 2016 and 2020, requiring the participation of at least 50% of the oncology providers in the country.
Timeframe: Initiation April 2016 - End Date December 2019

9. Continue ongoing current vaccine based and other immunotherapy clinical trials at NCI in collaboration with Dr. Jeffrey Schlom and Dr. James Gulley and initiate amended and/or new randomized Phase II trials for up to 20 tumor types.

Timeframe: Continuation of current trials: January 2016
Timeframe: Initiation of amended trials: March 2016
Timeframe: Initiation of new immunotherapy based Phase II Trials: June 2016

10. Report status of MoonShot program and QUILT trials in 18 months with regard to:

A. Number of patients evaluated
B. Number of oncologists participating
C. Number of pharmaceutical companies participating
D. Number of self-insured & insurance companies participating
E. Number of protocols initiated
F. Number of patients entered into trials
G. Number of patients dosed
H. Patients outcomes vs. standard of care to date

Timeframe: First report January 2017 (Immunotherapy Summit 2017, Santa Cruz, CA)
Second report August 2017 (Breakthroughs in Medicine & Technology Summit, Jackson Hole, WY)

ATTENDEES

National Immunotherapy Coalition

December 1, 2015

HOST

Vice President Joe Biden
47th Vice President of the United States
White House

ATTENDEES

WHITE HOUSE

Don Graves
White House
Deputy Assistant to the President and Counselor to the Vice President

FDA

Robert M. Califf, M.D.
U.S. Food and Drug Administration
Deputy Commissioner for Medical Products and Tobacco

Janet Woodcock, M.D.
U.S. Food and Drug Administration
Director of the Center for Drug Evaluation and Research (CDER)

Peter W. Marks, M.D., Ph.D.
U.S. Food and Drug Administration
Deputy Director for the Center for Biologics Evaluation and Research (CBER)

NCI

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Center for Cancer Research, National Cancer Institute, National Institutes of Health
Chief - Laboratory of Tumor Immunology and Biology

James L. Gulley M.D., Ph.D., F.A.C.P.
Center for Cancer Research, National Cancer Institute, National Institutes of Health
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Director - Medical Oncology Service

ATTENDEES

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Tufts University School of Medicine
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Ralph H. Hruban, M.D.
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Professor of Pathology & Oncology at Johns Hopkins University School of Medicine
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University of Miami Health System
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Biochemistry & Molecular Biology and Professor of Medicine

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Harvard Medical School, Physician at Massachusetts General Hospital

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Columbia University
Director of the MDS Center, Professor of Medicine

Col. Craig Shriver, M.D., F.A.C.S.
Walter Reed National Military Medical Center
Colonel, Medical Corps, United States Army
Director, John P. Murtha Cancer Center

Patrick Soon-Shiong, M.D., F.R.C.S.(C), F.A.C.S.
NantWorks & Chan Soon-Shiong Institute of Molecular Medicine (CSSIOM)
Founder & Chairman

ATTENDEES

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Chairman & Chief Executive Officer

Paul Seligman, M.D., M.P.H.
Amgen
Chief of R&D Policy

Sir Andrew Witty
GlaxoSmithKline
Chief Executive Officer

Patrick Vallance
GlaxoSmithKline
President, Pharmaceuticals Research & Development

Mikael Dolsten, M.D., Ph.D.
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President, Worldwide Research & Development

Frank Jones, M.D.
Etubics Corporation
President, Chief Executive Officer, Chief Scientific Officer

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Allscripts
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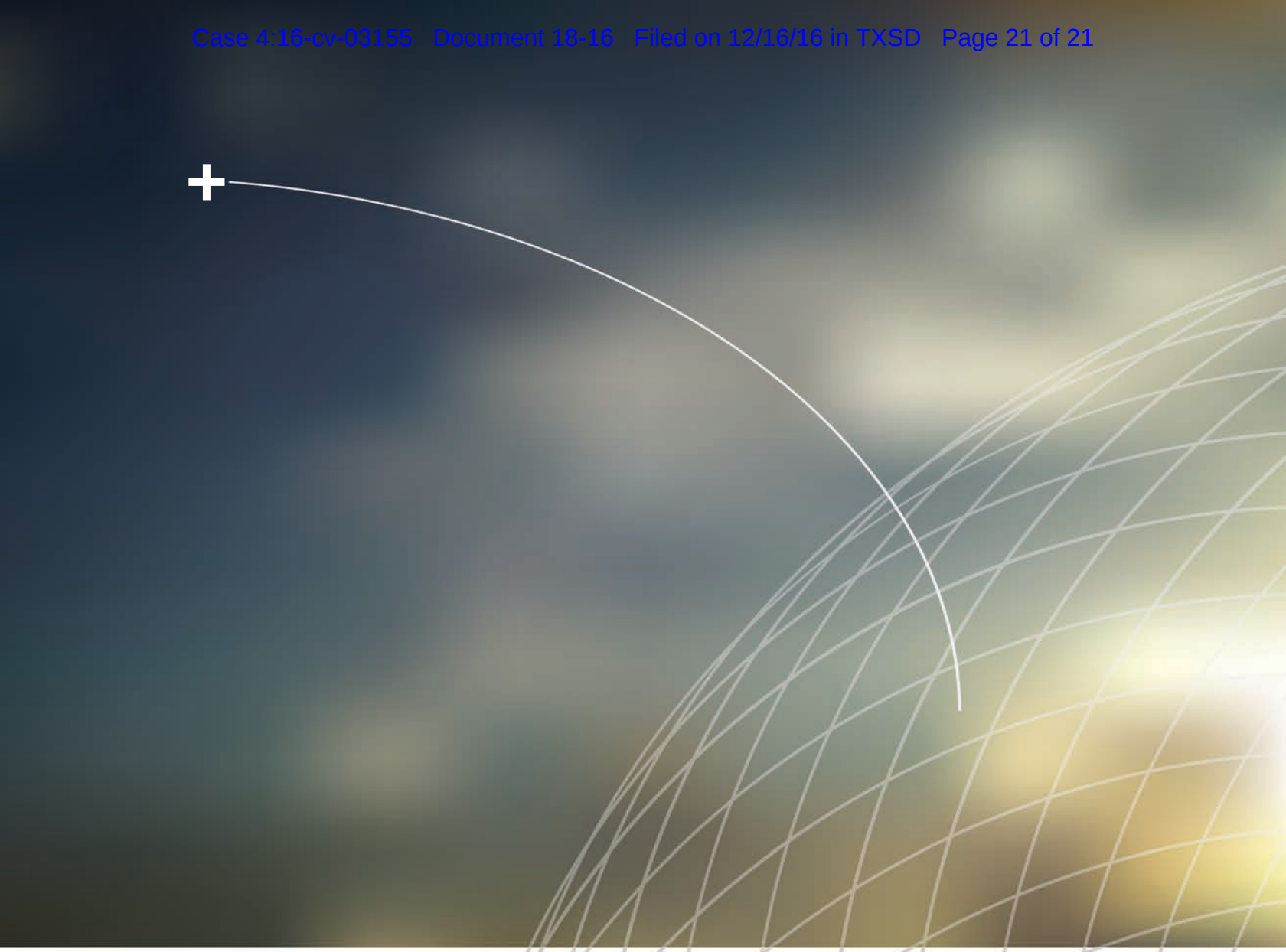

National Immunotherapy Coalition

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